

| Patient Information |
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| Patient Name: _____ |
| Date of Birth: _____ Sex: _____ Caregiver: _____ |
| Address: _____ |
| City: _____ State: _____ Zip: _____ |
| Home Phone: _____ Work Phone: _____ |
| Cell Phone: _____ E-mail: _____ |
| <small>Please attach copy of front and back of patient's prescription ins. card(s) if applicable</small> |
| Insurance Company Name: _____ |
| Insurance Company Phone: _____ |
| Policy holder: _____ |
| Policy holder Employer: _____ |
| Relationship to Patient: _____ |
| ID# _____ Group# _____ |
| RxBIN: _____ RxPCN: _____ |

| Prescriber Information |
|---|
| Practice/Organization Name: _____ |
| Physician Name: _____ |
| Address: _____ |
| City: _____ State: _____ Zip: _____ |
| Phone#: _____ Fax#: _____ |
| DEA# _____ NPI# _____ |
| License#: _____ Medicaid UPIN#: _____ |
| Physician Specialty: _____ |
| Date Shipment Needed: _____ |
| Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Prescriber <input type="checkbox"/> Infusion Clinic |
| Shipment Address: _____ Attn: _____ |
| City: _____ State: _____ Zip: _____ |
| <small>If shipped to the physician's office, physician accepts on behalf of patient for administration in office.</small> |

| Clinical Information and Prescription |
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| Diagnosis: <input type="checkbox"/> K51.____ Ulcerative Colitis of the _____ |
| Other: _____ ICD 10 Code: _____ |
| Date of Diagnosis or Years with Disease: _____ |
| Patients Allergies: _____ |
| Latex allergy: <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Patient Weight: _____ kg or lbs Patient Height: _____ |
| Has the patient had a NEGATIVE tuberculin skin test? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Has Hepatitis B been ruled out? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Prior Medications and length of treatment: _____ |
| Expected First Dose Date: _____ |
| Injection Instruction needed: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> In-Office Training |

| Ulcerative Colitis Treatment Selection: |
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| <input type="checkbox"/> Entyvio® (vedolizumab) infuse Entyvio in NS 250ml over 30 minutes as directed <input type="checkbox"/> Initial Dose: 300mg IV @ 0, 2, 6 weeks <input type="checkbox"/> Maintenance Dose: 300mg IV every 8 weeks |
| <input type="checkbox"/> Humira® (adalimumab) <input type="checkbox"/> 40mg Prefilled Syringe OR <input type="checkbox"/> 40mg Pen Auto Injector <input type="checkbox"/> Citrate/buffer free <input type="checkbox"/> Starter Kit: 160 mg SC on day 1, 80 mg on day 15, then 40mg every other week <input type="checkbox"/> Maintenance Dose: 40mg SC every other week |
| <input type="checkbox"/> Remicade® (infliximab) OR <input type="checkbox"/> Inflectra® OR <input type="checkbox"/> Renflexis® infuse in NS 250ml over 2 hours as directed Initial Dose: <input type="checkbox"/> 5mg/kg @ 0, 2, 6 weeks Maintenance Dose: <input type="checkbox"/> 5mg/kg every 8 weeks <input type="checkbox"/> 10mg/kg every 8 weeks <input type="checkbox"/> Other Remicade dosing: _____ |
| <input type="checkbox"/> Simponi® (golimumab) <input type="checkbox"/> Initial Dose: Inject 200 mg SC at Week 0, followed by 100 mg at Week 2 then every 4 weeks <input type="checkbox"/> Maintenance Dose: Inject 100 mg SC every 4 weeks |
| <input type="checkbox"/> Xeljanz® (tofacitinib) <input type="checkbox"/> Initial dose: 10 mg PO twice daily for at least 8 weeks Maintenance Dose: <input type="checkbox"/> 5 mg PO twice daily <input type="checkbox"/> 10 mg PO twice daily |

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| Quantity Prescribed: <input type="checkbox"/> QS 30 Days <input type="checkbox"/> other: _____ |
| Refills Authorized: <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 6 mos <input type="checkbox"/> 1 yr <input type="checkbox"/> Other: _____ |
| X |
| _____ |
| Physician Signature (no stamps) |
| Date |

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